Review of the Literature on Migrant Mental Health

Canadian Task Force
on Mental Health Issues
Affecting Immigrants
and Refugees

Canada

CANADIAN TASK FORCE ON MENTAL HEALTH ISSUES
AFFECTING IMMIGRANTS AND REFUGEES

REVIEW OF THE LITERATURE ON MIGRANT MENTAL HEALTH

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EXECUTIVE SUMMARY

Mandate

To review the current knowledge, based on research, regarding the mental health status of immigrants and refugees and the mental health services which are or should be available to them.

Findings on Mental Health Status

The Task Force reviewed over 1000 publications as well as unpublished reports, from which the following points have been distilled.

Migration per se does not predict an increased risk of mental disorder. However, certain ontingencies may be part of the migration experience. When they occur, they increase the risk of developing mental disorder. These contingencies include:

1. drop in personal socio-economic status following migration;
2. inability to speak the language of the host country;
3. separation from family;
4. lack of friendly reception by surrounding host population;
5. isolation from persons of similar cultural background;
6. traumatic experience or prolonged stress prior to migration; and
7. adolescent or senior age at time of migration.

Migrant sub-populations characterized by some or all of these variables appear to be at greatest risk for mental disorder sometime between three and 18 months after arrival. A second period of elevated risk, which develops years after migration, may be associated with the emergence of family problems.

Findings on Mental Health Services

The most effective measures for preventing mental ill health address the issues of socioeconomic status and sociocultural support. Language and job-training programs, policies facilitating family reunification and community organization, and positive reception by host populations have the potential to prevent mental disorder and enhance positive psychosocial adaptation.

Remedial mental health services are used less frequently by migrants than by native-born persons. Cultural concepts of mental disorder, particularly the intense stigma attached to it, lead to acceptance, concealment and/or somatization of mental health problems. Many cultural groups feel it is inappropriate to seek formal treatment for emotional problems.

When migrants do seek mental health services, linguistic and cultural differences often preclude successful treatment outcome. Misdiagnosis, non-implementation, and premature termination result when the cultural implications of symptoms, counselling approach and treatment plan are not taken into consideration.

Traditional healers from migrant communities have proven valuable to mainstream practitioners as consultants, trainers, and co-therapists.

Implications for Action

1. **Expansion of Programs and Policies Facilitating Socio-Economic and Socio-Cultural Adaptation Among Migrants**. For maximum cost-efficiency, existing programs and policies should be evaluated from a mental health perspective. For example, what are the implications of professional accreditation versus job-training for emotional well-being?

2. **Development of Community Education and Outreach Programs for Migrant Populations**. These should be based on accurate information regarding each cultural group's present perceptions of mental disorder and mental health services. For example, what use does each group make of traditional healing practices, if any?

3. **Provision of Cross-Cultural Training for Mental Health Practitioners and Mental Health Training for Bicultural Interpreters**. This requires the development, implementation, and evaluation of skills-oriented curricula. For example, what modifications in counselling techniques are called for when working with a rape victim from a traditional cultural background?

4. **Standardization of Cross-Culturally Valid Research Methods for Assessing Mental Health and Mental Health Services**. The effectiveness of each of the actions called for above depends on the extent to which they are based on accurate and sensitive information. Such information in turn depends on the use of tested and proven research methods.

I. SCOPE OF THE LITERATURE REVIEW

The literature review consists of two main sections, the first addressing the mental health status of immigrants and refugees and the second, mental health services. By way of introduction, the goals, methods and limitations of the review itself are noted.

The Task Force's objective in reviewing the literature on migrant mental health is to determine the current state of academic thought and research regarding mental health issues affecting immigrants and refugees. Three goals serve to meet this objective:

1. identification of the problems confronting research in the area, and the limitations such problems place on findings;

2. identification of the range of issues addressed by the literature, and the gaps in knowledge and understanding;

3. identification of the general direction of findings, and any significant inconsistencies between findings.

Not only the findings of academic research, but also the problems and gaps which characterize it, form the recommendations of the Task Force.

The literature considered for the review was identified in two ways. Initially, computerized searches were carried out on four data bases: Health Planning and Administration, Medline (a data base covering publications in all fields of the health sciences), Psychological Abstracts, and Sociological Abstracts. Approximately 700 references to publications concerning migrant mental health were generated through these computerized searches. Secondly, Task Force members compiled supplementary lists of references to published works and unpublished papers presented at academic conferences. In total, just over 1000 references were identified and considered for the review.

The scope of the literature selected for the review reflects the mandate of the Task Force as described in the Introduction to this report. It includes studies which range from one end to the other of the mental health continuum, from emotional well-being, to psychological distress, to psychiatric disorder. It is also inclusive with regard to the literature on mental health services: publications concerning preventive programs, traditional healing practices, and mainstream services of private practitioners, community treatment centres, and hospital facilities are all reviewed.

Also in accordance with the mandate given, the literature selected includes studies of immigrants and refugees regardless

of how long the subjects have resided in their host countries. It excludes research on aboriginal groups, transient migrant workers, foreign students, and other sojourners. A few publications in the area of ethnicity and mental health are included, where the ethno-cultural group(s) concerned contain a large proportion of first-generation migrants, as well as native-born persons.

To ensure the relevance and practicality of the literature review, members of the Task Force determined that the publications selected should focus on contemporary material relating to the Canadian context. Most references, therefore, are to works carried out within the past decade. Canadian research findings are presented along with comparative data from other Western countries of immigration, such as Great Britain and the United States. However, also for practical reasons, only references available in one of Canada's official languages are cited.

A final word regarding the scope of the literature review: some of the references cited offer empirical data and quantitative documentation, while others concern in-depth case studies, theoretical works, and/or statements of advocacy based on practical experience. By including both qualitative and quantitative materials in its review, the Task Force feels that it is able to capture and reflect the essential nature of academia's contribution to the understanding of migrant mental health.

II. MENTAL HEALTH STATUS OF IMMIGRANTS AND REFUGEES

Two themes dominate recent literature concerning the mental health of migrants. One focuses on the question of measurement: How can mental health be measured in populations from diverse cultural backgrounds? The second theme concerns the question of cause: To the extent that mental health rates can be shown to vary between migrant and native-born populations, or between different migrant sub-populations, which factors are associated with greater mental health risk? These are not "merely academic" questions. In the answers to them lie the ingredients for effective planning of preventive and remedial mental health services.

A. MEASURES OF MENTAL HEALTH STATUS

Assessments of the mental health of migrant populations are usually based either on clinical data, such as hospitalization rates, or on community surveys. Either approach raises the central concern of cross-cultural validity.

1. Community Surveys

When insufficient attention has been paid to the cross-cultural equivalence of concepts, measures, and sampling frames, the interpretation of surveys becomes difficult (Casas, 1985; Eyton and Neuwirth, 1984). To achieve conceptual equivalence, attempts have been made to translate supposedly universal, "etic" mental health terms into other languages, and to re-standardize them in non-English-speaking populations (D.W. Chan, 1985; Fava, 1983; Karno et al., 1983). Alternatively, by working with key informants to gain an understanding of indigenous concepts of illness and ways of expressing distress, culturally unique "emic" items and scales have been developed for the assessment of mental disorders within specific cultural groups (Kinzie et al., 1982). A few scholars have combined emic and etic approaches for use with both migrant and host populations (Beiser and Fleming, 1986; Cochrane, Hashmi and Stopes-Roe, 1977).

The cross-cultural validity of quantitative measures used in community surveys depends to a large extent on the degree to which symptoms, feelings and experiences are attended to and reported in different cultural groups (Westermeyer, 1985). In the first instance, ratings assigned to items in a mental health scale reflect a culturally specific model of the syndrome to be measured (Eyton and Neuwirth, 1984; Lonner, 1980). More importantly, a migrant's responses to the items may be influenced by such factors as culturally specific

concepts of etiquette (Aday, Chiu and Anderson, 1980; Jones and Korchin, 1982). Several researchers recommend that before any attempt is made to quantitatively assess differences in mental health status between cultural groups, a qualitative assessment on the basis of open-ended interviews and detailed phenomenological description is called for (Eyton and Neuwirth, 1984; S. Sue, 1983).

Finally, the interpretation of data generated by cross-cultural community surveys is complicated by the range of socio-demographic variables which may or may not be controlled for by the sampling techniques (Casas, 1985; Jones and Korchin, 1982). Findings based on carefully matched samples of migrant and native-born populations cannot be extrapolated from if the matched factors are not representative of the two populations at large (see for example Cochrane and Stopes-Roe, 1981). On the other hand, studies based on random samples require considerably large numbers -- and large research grants -- if the explanatory variables are to be identified at any statistically significant level (see for example Beiser, 1984).

2. Clinical Data

Measurements of mental health status based on hospitalization rates and other clinical data have often been challenged on the grounds that they confuse occurrence of psychiatric disorder with patterns of health-care seeking (Lopez, 1981). Factors such as proximity to treatment services and fear of stigma affect decisions to seek or avoid treatment when illness occurs. If such factors operated the same way among all sub-groups in a society, treatment rates would at least offer the possibility of comparing relative risk of disorder. However, since migrant and native-born populations use the health-care system differently, studies which rely on hospitalization rates as an index of relative mental health status must be viewed with caution (Allodi and Fantini, 1985; Morgan and Andrushko, 1977; Rwegellera, 1980).

Further complications, associated with the task of cross-cultural diagnosis, arise when clinical records are used to suggest rates of specific disorders in migrant populations (Boxer and Garvey, 1985; Carpenter and Brockington, 1980; Littlewood and Lipsedge, 1981). The issues of cross-cultural diagnosis, and also those of utilization patterns, are elaborated below, pp. 20-27.

3. Rates of Mental Disorder

Ideally, the mental health status of migrant populations should be assessed by cross-culturally valid community

survey methods in parallel with an examination of patterns of clinical measures, the results of the one inquiry supporting and highlighting those of the other (see, for example, Cochrane and Stopes-Roe, 1981). Actual research findings, however, rarely present such a clear picture. Several community-based studies suggest lower rates of psychological distress among migrants than among native-born persons (Halldin, 1985; Kallarackal, 1976; Roskies, 1978), but at least one survey has found significantly higher rates of psychological distress among migrants (Vega, Kolody and Warheit, 1985; see also Yeung and Schwartz, 1986). In contrast, clinical studies of hospitalization statistics tend to show higher rates of psychiatric disorders among migrants than among native-born persons (Carpenter and Brockington, 1980; Cheung and Dobkin de Rios, 1982; Dean et al., 1981), but, again, there are important exceptions (Bland and Orn, 1981; Morgan and Andrushko, 1977).

The methodological problems inherent in cross-cultural research explain some of these inconsistencies, but not all of them. There are sufficient contradictory results, from carefully designed and executed studies, to conclude that the experience of migration, in and of itself, does not determine mental health status. As Murphy (1977) points out, the question which must be asked is: Under what conditions do migrant populations have higher or lower rates of mental disorder than native-born populations?

B. FACTORS AFFECTING MENTAL HEALTH STATUS

In his critique of theories on mental illness among migrants, Salvendy (1983) argues that the majority of them fail to recognize the multifactorial nature of the etiology, particularly the predisposing factors, and that they focus on psychotic disturbances at the expense of lesser disorders. When these theories are reviewed as a whole, however, an extensive set of variables emerges which refer both to pre-migration and to post-migration contexts, and which relate to both psychiatric disorders and emotional distress (see for example Goldlust and Richmond, 1974).

Variables which antedate emigration include several socio-demographic factors and a number of conditions characterizing exodus. Each of these pre-migration forces affects the impact of various post-migration factors, including the length of stay in the country of resettlement. The task at hand is to identify which combinations of these variables define sub-populations of migrants at special risk for mental disorder.

1. Socio-demographic Variables

Among the socio-demographic variables thought to affect migrant mental health, age and sex are the most easily operationalized and the most often tested. Socio-cultural factors such as urban or rural background, level of education, and occupational class can be ascertained with relative certainty and have been examined in relation to a number of migrant groups. Genetic variables are also thought to affect migrant mental health, but they are difficult to operationalize for a number of methodological reasons and have rarely been tested with any certainty (Cochrane, 1979; Hull, 1979; Murphy, 1977).

a) Age at time of migration. Migrants in certain age groups appear particularly vulnerable to the stresses of adaptation. Adolescents and young adults face developmental demands and maturational identity crises at the same time that they encounter new situational demands and cultural identity crises (Léger et al., 1983; Miller, Chambers and Coleman, 1981; Naditch and Morrissey, 1976). Studies have linked migration at the time of adolescence with subsequent alcohol abuse (Morgan, Wingard and Felice, 1984), drug addiction (Amaral Dias et al., 1981), delinquency (Burke, 1982), and depression (Skhiri, Annabi and Allani, 1982).

A few studies suggest that persons who migrate between the ages of six and eleven are also vulnerable to stress, but not until several years after migration (Inbar, 1977; Schrader, 1980). Their difficulties at that time appear closely related to their parent's attitudes towards host country values (B.K. Kim, 1977; Kurian, 1986).

Seniors constitute a second age-based category who seem particularly vulnerable to the stress of migration (Ikels, 1983; Kurzeja et al., 1986; Naidoo, 1985). As Smither and Rodriguez-Giegling (1979) point out, this may be attributable to the common sense notion that adaptation becomes more difficult after a certain age. Because they are slower to adapt, elderly migrants are often not consulted for advice by their families as they would be in their countries of origin, and the advice that they do offer often goes unheeded (Lum et al., 1980; Spitzer, 1984). The consequent loss of self-esteem, sense of isolation, and depressive symptomatology can be expected to increase over time as the values of younger migrants continue to shift away from traditional patterns (Miller, Chambers and Coleman, 1981).

Recent studies of elderly Chinese Canadians in Toronto (K.B. Chan, 1983) and elderly Japanese Canadians in Vancouver (Shibata, 1980) suggest that persons who immigrate earlier in life may choose to live independently of their families in old age, as a means of reducing family conflict and safe-guarding self-identity (see also Gerber, 1983).

b) Sex of the migrant. An extensive body of literature, most of it qualitative (but see Walter, 1981), focuses on the female migrant. It notes the stress created by the contrast in women's roles between non-Western countries of emigration and Western countries of resettlement (Castro, 1982; Costello, 1980; Naidoo, 1984). In particular, changes in traditional family patterns are associated with emotional distress in women (Mirdal, 1985; Morokvasic, 1984; Rahim and Mukherjee, 1984). Responding to the perceived needs of migrant women, numerous specialized programs and services have been advocated, developed, and implemented (Crandall, Day and Reny, 1982; Marshall, 1979; Palmer, 1981).

Some quantitative research suggests that female migrants have a higher risk of developing emotional disorder than males (Carpenter and Brockington, 1980; Halldin, 1985). In a survey of Portugese immigrants in Montreal, for example, women exhibited higher rates of mental disorder than men (Roskies, 1978). Similarly, an analysis of Canadian suicide statistics showed that 60 per cent of female immigrant groups demonstrated higher suicide mortality rates than those obtaining in their countries of origin, while only 41 per cent of male groups did so (Kliewer and Kazanjian, 1986). However, other studies have reached quite different conclusions: a survey of North African Jewish immigrants in Montreal found that sex was not significantly related to mental health scores (Lasry and Sigal, 1980). A second analysis of Canadian suicide statistics revealed that immigrant males in the 15-34 year-old category have higher suicide mortality rates than women in the same age group (Trovato, 1986).

These apparently contradictory findings suggest that there is nothing inherent in maleness or femaleness that explains differences in the mental health rates of migrant men and women. Rather, the variable of sex cross-cuts many of the other factors identified in relation to mental health status, factors which differentially affect males and females. For instance, with regard to the age categories discussed above, female adolescents are more likely to have traditional

restrictions placed on them in the immigrant context than are male adolescents (B.K. Kim, 1977; Ruiz and Padillo, 1977). Similarly, although both senior men and senior women suffer status dislocation and loss of self-esteem, elderly women are more likely to experience loss of spouse in addition to loss of country, and are more likely to remain housebound in the country of immigration (Penning, 1983; Rahim and Mukherjee, 1984). Male migrants, on the other hand, appear particularly affected by certain post-migration variables, especially occupational and employment status (see pp. 13-14).

c) Socio-cultural background. A few studies support the conventional wisdom that the risk of mental disorder varies with the degree of social and cultural contrast between the place of origin and the place of destination (Danna, 1980). However, Smither and Rodriguez-Giegling (1979) found no correlation between indices of modernity and indices of anxiety among Vietnamese and Laotian refugees. The association between situational stressors and poor health found among Samoan immigrants to Auckland was replicated within the matched native-born sample (Graves and Graves, 1985). In Australia, migrant men from New Zealand and Scotland had significantly higher rates of suicide than did migrant men from Italy, Greece, or India (Burvill, Armstrong and Carlson, 1983). As Hull (1979) points out, the migrant and the experience of migration can be so variable that the change of habitat may be the least important characteristic of the event (see also Burvill, 1982).

One aspect of socio-cultural background which does appear related to migrant mental health is that of language: the degree of fluency in the language of the host country is positively related to adaptation (Maingot, 1985; S.D. Nguyen, 1982). Inability to speak the host language has been associated with schizophrenia in men (Bland and Orn, 1981), depression in women (Williams and Carmichael, 1985), and behavioural deviance in children (Marcos, 1982; Stevenson, Richman and Graham, 1985). A study conducted in California using the Health Opinion Survey found that 6.6 per cent and 5.5 per cent of English-speaking Mexican Americans and "other whites" scored above the cut score, respectively, but 15.4 per cent of Spanish-speaking Mexican Americans scored above it (Vega, Kolody and Warheit, 1985).

Interestingly, a migrant's level of education is not necessarily associated with his or her level of

adjustment and, in some cases, has proven to be inversely related (L.T. Nguyen and Henkin, 1982; Westermeyer, Neider and Vang, 1984). A study of Polish immigrants in Edmonton (Fantino and Kennedy, 1983), and one of Vietnamese refugees in the United States (Starr and Roberts, 1982) conclude that while English-language ability is positively associated with personal well-being, higher levels of education tend to predict greater difficulties in adjustment.

2. Conditions of Exodus

As a rule, the conditions surrounding exodus vary in the first instance depending on whether the migrant is an immigrant or a refugee. Sources of pre-migration stress, the composition of the migrating unit, and expectations regarding the future tend to pose greater problems for refugees than for immigrants. An awareness of a migrant's history with regard to such conditions of exodus helps to predict his or her patterns of adaptation (Kunz, 1981; Tyhurst, 1982).

a) Pre-migration stress. In the case of immigrants, the degree of stress associated with leaving a homeland may be determined in part by cultural and/or governmental attitudes towards emigration and emigrants (Hull, 1979; Murphy, 1977; Shuval, 1982). Moreover, the attitude of the migrant himself/herself is rarely without ambivalence: the decision to leave is often imposed by substantial economic constraints which supercede personal and familial considerations, particularly those of women and children (Sell, 1983; Shuval, 1982; Sluzky, 1979).

In the case of refugees, not only is the "decision" to migrate a forced one, it is also irrevocable: several researchers liken the experience of exile and its psychological manifestations to bereavement (Disman, 1983; Fantino, 1982; Munoz, 1980). Moreover, prior to their exodus many refugees have lived for years with the turmoil of war (Boman and Edwards; 1984); many have experienced perilous escapes and the loss of family members and friends who did not escape (Alley, 1982); often, extended periods of time have been spent in overcrowded and unsanitary camps (S.D. Nguyen, 1982).

Numerous clinical and community-based studies suggest that these ordeals affect mental health (Eisenbruch, 1983; Goldfield and Lee, 1982; Krupinski, 1984; Tobin and Friedman, 1983). Yet some of the post-migration factors discussed below can mitigate the effects of pre-migration stress and in some cases have been found

to correlate more highly with mental health outcome (Kunz, 1981). For example, Westermeyer, Vang and Neider (1983a) report that pre-migration factors had little influence on the mental health of Laotian refugees one and a half years after resettlement, but early refugee placement and social adjustment factors (e.g., avocational and social roles) had a major influence. Similarly, Starr and Roberts (1982) found that the number of undesirable life events experienced by Vietnamese refugees was not significantly related to levels of personal well-being, but occupational status in the country of resettlement was.

Within refugee populations, victims of torture constitute a sub-population at special risk for mental disorder. In comparison with other refugees, survivors of torture have been found to have experienced a greater number of life changes and to be more troubled by these changes (Allodi and Rojas, 1983; Duran, 1980; see also Sehl and Naidoo, 1985). Allodi and Cowgill (1982) suggest that the psychiatric symptoms manifested by some victims should be recognized as constituting a torture syndrome, distinguishable from the post-traumatic stress disorder diagnosed in some survivors of concentration camps (see Kinzie et al., 1984).

Research on the psychological consequences of torture is needed and is progressing. At least two related issues, however, have yet to be examined in any detail. First, although the children and spouses of torture victims are known intuitively to experience heightened levels of emotional distress, the prevalence, etiology and treatment implications of their problems have not been established (Allodi, 1980). Secondly, women who have been raped constitute a sizeable sub-population of refugees who may well be as much at risk for mental disorder as other victims of torture, but their fear of shame, reprisal or ostracism renders assessment exceedingly difficult (Hutchinson, 1985; Van Drunen, 1982).

b) Family composition. The composition of the migrating unit receives considerable attention in the literature. Single migrants, married persons whose spouses have been left behind, and parents or children separated from one another have been found to be at particular risk for mental disorder (Bathien and Malapert, 1983; Burke, 1980; Miller, Chambers and Coleman, 1981).

As in the case of pre-migration stress, however, there

are indications that certain post-migration variables may relate more directly to mental health status than do variations in the completeness of migrating units. For instance, one study of Vietnamese refugees hypothesized a relationship between psychological distress and families who had left members behind in Vietnam (Yamamoto et al., 1976). It concluded instead that the head of household's employment status following resettlement was the significantly related variable (see also Minde and Minde, 1976). If family reunification is a theoretical possibility, employment income may be viewed by migrants as a means to its realization, rendering employment status as important as the fact of separation at the time of exodus.

The positive role played by relatives other than those of the nuclear unit has been noted by several authors (Brodsky, 1982; Fantino and Kennedy, 1983; Haines, Rutherford and Thomas, 1981). When present, the extended family constitutes perhaps the most common coping mechanism for migrants, enabling them to deal with normal life-crises in familiar ways (Alcalay, 1984; Cheung and Dobkin de Rios, 1982; Fandetti and Gelfand, 1978). Lack of extended family support is associated with emotional problems and psychiatric disorder, particularly in women (Lynam, 1985; Rahim and Mukherjee, 1984; Williams and Carmichael, 1985). Certainly, intergenerational conflicts related to adaptation are well documented by the literature on migrant family relations (Lum et al., 1980; Mangalam, 1986; Wakil, Siddique and Wakil, 1981). As K.B. Chan (1984a) points out, however, it is by comprehending the rootedness and imbeddedness of migrants in their extended family networks that their psychosocial behaviour during resettlement can be understood.

c) Expectations of the future. All other factors being equal, the migrant who has realistic expectations of his or her future life is more likely to adapt successfully to that life than one whose expectations are overly optimistic (David, 1969; Murphy, 1977). For a few migrants, both immigrants and refugees, previous experience abroad may dispel at least some illusions regarding resettlement (Beiser, 1984). In most instances, however, the key to realistic expectations lies in active preparation for migration through the acquisition of accurate information (Rumbaut, 1977; U.S. Catholic Conference, 1985).

Without such preparation, as Haavio-Mannila and Stenius (1977) point out, the appropriateness of a migrant's expectations is inversely related to the geographic

distance between his or her homeland and the host country. With preparation, through "relevant, detailed, realistic and up-to-dated information," the selection of migrants can be positively affected from a mental health perspective (Salvendy, 1983).

Although the time available for preparation is often limited and obstructed in the case of refugees as compared to immigrants, for both categories of migrants it represents a first and very important opportunity for primary preventive mental health services (Cohon, 1981).

3. Post-migration Variables

The post-migration factors affecting migrant mental health are closely related to one another. Variations in host country reception have much to do with variations in migrant economic status and community composition. In turn, a migrant's socio-economic status and community of residence influence the effect which length of stay has on his or her mental health. Below, the literature which addresses each of these post-migration variables is discussed separately, but the factors themselves constitute an interrelated whole.

a) Reception by host society. Everything from national policy to neighbourhood attitudes can either facilitate or inhibit migrant adaptation (Berry, 1984). However, few specifics have been established regarding the impact of such policies and attitudes on migrant mental health (Cheung and Dobkin de Rios, 1982; Fernando, 1984; Westermeyer, Vang and Neider, 1983b).

In the Canadian context, Bhatnagar (1980) reports that immigrant children who use a native language as well as French or English in their social relations at school are better adjusted than children who use only French or English. Fry (1985) relates his findings on stress among Vietnamese youth to their involvement with mainstream vocational agencies. A few studies have examined the relationship between type of sponsorship and refugee adaptation (Johnson, 1984; Neuwirth et al., 1985). One of these (Beiser, 1984) notes that among church-sponsored refugees, the risk of depression is higher for persons of Buddhist or Animist persuasion, and lower for persons of Christian or no religious persuasion. For the most part, however, the implications of many policies and programs -- orientation services, professional accreditation requirements, job training and French or English language classes -- remain unexamined from a mental health perspective.

With regard to Canadian attitudes towards migrants, the negative impact of perceived racism and discrimination has been noted in relation to migrant employment, housing, and education (Head, 1979; Naidoo, 1986; Ubale, 1977). But again, in relation to mental health outcome, few specifics are presented: Fantino and Kennedy (1983) found that among Polish immigrants in Edmonton, perceived acceptance by Canadians was significantly associated with perceived adaptation.

The dearth of concrete information relating host country reception to migrant mental health may be due in part to the fact that the relationship is logically obvious and intuitively known. It stands to reason that orientation services, or accepting attitudes, are conducive to migrant adaptation and emotional well-being. Nevertheless, empirical research in the area is needed in order to determine how the advocated policies are best implemented, and how positive attitudes are best demonstrated, from the migrant's point of view.

b) Socio-economic status. The central importance of socio-economic status as a factor in migrant mental health emerges from the above discussion of conditions of exodus (pp. 9-12). Satisfactory employment in the country of resettlement has been found to correlate more highly with emotional well-being than either pre-migration stress or family separation (Minde and Minde, 1976; Starr and Roberts, 1982; Westermeyer, Vang and Neider, 1983a, 1983b; Yamamoto et al., 1976).

The literature defines socio-economic status in one of two ways. In absolute terms, it notes that unemployment and low incomes constitute sources of stress for migrants as they do for native-born persons (Cheung and Dobkin de Rios, 1982; Neuwith et al., 1985; Richmond, 1982). Since low socio-economic status is known to be a strong predictor of poor mental health, the objective picture of migrants' financial circumstances warrants consideration by researchers (Dohrenwend et al., 1980; Korchin, 1980). In Canada, an analysis of recent statistics indicates that while male migrants as a whole have higher incomes than non-migrants, those from developing countries tend to have lower than average incomes (Verma and Basavarajappa, 1986).

The literature which defines socio-economic status in relative terms suggests that relative economic status -- the difference between the status perceived in the

host country and that recollected from the homeland -- is more critical to migrant mental health than is absolute economic status (Boman and Edwards, 1984; Hopkins-Kavanagh and Sananikone, 1981; Vignes and Hall, 1979). Particularly for men, the suitability of employment, as determined by past professional status, represents a key factor in adjustment (Guidote and Baba, 1980; S.D. Nguyen, 1982). A drop in men's socio-economic status may precipitate psychological symptoms and possibly suicide in the men themselves (K.B. Chan and Lam, 1983; Trovato, 1986) as well as creating stress for their wives (Hirayama, 1982) and pathology in their children (Minde and Minde, 1976).

c) Community composition. A persuasive number of studies suggests that resettlement among members of one's own cultural group is conducive to migrant mental health (K.B. Chan, 1984b; Giordano and Giordano, 1977; Smither and Rodriguez-Giegling, 1979). In addition to facilitating the maintenance of important customs and beliefs, residence in an "ethnic enclave" appears to mitigate the effects of pre-migration stress and to provide a buffer against post-migration sources of stress (Beiser, unpublished; Yedid, 1982; Way, 1985). Interestingly, the presence of a cultural community may be as significant to the emotional well-being of migrant children as it is to their elders (Huych and Fields, 1981; Olowu, 1983; Ready, n.d.).

Relative cultural isolation has been associated not only with levels of psychological distress but also with risk of psychiatric disorder. In Canada, an analysis of first admissions for schizophrenic patients found that, while migrants as a whole were not over-represented, minority cultural groups and minority language groups were over-represented (Bland and Orn, 1981). Similarly, Murphy (1973) found that the mental hospitalization rates of Canada's migrant groups tended to increase as the size of the groups decreased.

A few scholars suggest that it is not the "ethnic enclave" per se which promotes mental health, but rather the feeling of support and belonging usually associated with it. They point out that where this feeling is not forthcoming -- for example, where a cultural group lacks social cohesion, or where it lacks sufficient numbers to provide a supportive environment -- the rates of mental disorder tend to be higher than in communities where social cohesion and support do obtain (Hitch and Rack, 1980; Myers and Neal, 1978).

In one of the earliest studies to analyze rates of

mental disorder in relation to community composition, Murphy (1955) found that either residence in a large cultural community or the presence of a friendly surrounding host population was conducive to mental health (see also Starr and Roberts, 1982).

d) Length of stay. There is general agreement in the literature that migrants go through different stages or phases during resettlement, and that some of these phases are characterized by higher levels of mental health risk than others (Grinberg and Grinberg, 1984; Sluzki, 1979; Tyhurst, 1982). There is also general agreement that recent migrants are at greater risk of mental disorder than are longer-term migrants (Alley, 1982; Guidote and Baba, 1980; Lasry and Sigal, 1980). However, of the two phases consistently associated with elevated mental health risk, one pertains to recent migrants and the other to migrants settled for several years or more.

For recent migrants, a period of elevated mental health risk has been found to develop sometime between three and eighteen months after arrival (Boman and Edwards, 1984; S.D. Nguyen, 1982; Sokoloff, Carlin and Pham, 1984). The migrants experiencing higher levels of psychological distress at this time tend to be those with lower levels of social support. Thus, among Indochinese refugees in Vancouver, rates of depression were found to peak late in the first year of resettlement, but primarily for persons living without their spouses and without a community of the same cultural background (Beiser, unpublished; see also Rumbaut, 1985). Similarly, among Hmong refugees settled for less than two years, high symptom levels were associated with infrequent visits from sponsors, lack of access to bicultural workers, and other variables of host country reception (Westermeyer, Vang and Neider, 1983a).

The second period of elevated mental health risk occurs several years after resettlement and is associated with the emergence of family problems (Barwick, 1986; Sluzki, 1979). For the most part, these problems are attributed to differential rates of acculturation within individual families: marital conflict occurs where husbands are exposed to the new country while their wives remain isolated, or where wives begin to seek greater autonomy than their husbands would have them (Roskies, 1978; Vignes and Hall, 1979). Intergenerational conflict characterizes families where children begin to adopt Western behaviour while parents remain comparatively traditional in their expectations

(Kurian, 1986; Skhiri, Annabi and Allani, 1982; Wakil, Siddique and Wakil, 1981). Such findings call into question the advantages of residence in an "ethnic enclave" over time. In so far as cultural communities differentially impede cultural adjustment by various family members, they may contribute to the family problems of longer-term migrants.

A few studies link the experience of psychological distress several years after resettlement with continued inability to speak the host country language and with continued loss in socio-economic status (K.M. Lin, Masuda and Tazuma, 1984; Westermeyer, Neider and Vang, 1984). However, as Westermeyer, Neider and Vang point out, the correlation does not indicate which of the factors is causal: emotional problems may interfere with the ability to learn and retain a new language or to gain suitable employment; conversely, lack of suitable employment and inability to communicate in the majority language may precipitate mental disorder. The authors suggest that the two sets of factors contribute to and exacerbate one another in a downward spiral.

C. MIGRANTS AT RISK

A review of the literature on migration and mental health highlights two major obstacles to determining the mental health status of immigrants and refugees. On the one hand, the methodologies employed by clinical and community-based studies are confounded by problems of cross-cultural equivalence. The findings of such studies may well be valid, but much work remains to be done on testing and proving the reliability of their methods across cultures. On the other hand, the theoretical foci of clinical and community-based studies tend to be unifactorial. Rarely are the various socio-demographic, pre-migration and post-migration variables controlled for within a single study, or operationalized so as to be comparable between studies.

When the theoretical foci of many studies are pooled, and the cross-cultural validity of their methodologies assumed, certain sub-populations of migrants emerge at greater risk of mental disorder than do others. The female adolescent or senior refugee who is unable to speak the language of the host country and who has unrealistic expectations regarding life in that country arrives at greater risk than does the adult immigrant male who speaks the language and whose expectations are well-informed. After resettlement, the migrant experiencing a relative drop in socio-economic status, who is living without members of his/her previous family, without a community of similar cultural background, and without supportive policies and attitudes from the host society is at higher risk than the migrant whose status

remains constant and who experiences familial, communal, and societal support.

Certain factors emerge as more significant to migrant mental health than others. Both for recent immigrants and refugees and for longer-term migrants, relative socio-economic status appears to play a major role in determining levels of emotional well-being. However, migrant economic status is closely tied to certain host country policies -- language and job-training programs, accreditation and certification requirements -- and, perhaps above all, to host country attitudes towards migrants.

Over 30 years ago, Murphy (1955, p. 193) termed a similar conclusion enheartening: "Now," he wrote, "we possess data suggesting that a relatively simple manipulation of current conditions may enable us to reduce the excess rates of mental breakdown by half."

III. MENTAL HEALTH SERVICES FOR IMMIGRANTS AND REFUGEES

Mainstream mental health services include hospitals, psychiatrists and psychologists in private practice, and community mental health programs. Much of the literature on meeting migrant mental health needs focuses on these mainstream facilities. However, increasing attention is being paid to less well-recognized places where people go for help. The primary health care system is one example: some authorities estimate that as many as 26 per cent of all medical care contacts are really for mental health problems (Hoeper et al., 1979). The traditional and folk healing systems are also used as mental health resources.

Prevention is receiving growing attention in the general health literature, and the field of migrant mental health is no exception. Increasingly, a body of information points the way to programs for preventing ill health and/or promoting well-being.

A. PREVENTIVE PROGRAMS AND SERVICES

Of the three categories of prevention, primary prevention -- the elimination of factors contributing to disorder and thereby preventing the disorder from ever occurring -- receives the most attention in the literature. Secondary prevention, concerned with the early diagnosis and treatment of disorder, is discussed below in relation to the utilization of mainstream mental health services (pp. 24-27). Few published works on migrant mental health even allude to tertiary prevention, or measures to reduce the negative consequences of disorder.

The primary preventive measures advocated for migrant populations address the problems resulting from lack of information, social and cultural isolation, and loss in socio-economic status (Allodi, 1984). Thus, many of the references cited above call for orientation programs, both prior to exodus and after resettlement; immigration policies which favour family reunification and initial settlement in "ethnic enclaves," and language and job-training programs (see also Plaut, 1985; Reubens, 1980; Strand and Jones, 1985). The empirical data available suggest that such preventive measures reduce psychiatric morbidity among migrants, and prove cost-effective in the short as well as the long run.

Several authors note that the effectiveness of host country policies and programs as preventive mental health measures depends largely on the way in which they are offered. Service providers must be well-trained and culturally sensitive (Cohon, 1981; Downie, 1985). The design of a program itself must be culturally appropriate (Brown, 1982; Elgie and Montgomery,

1985). One study of Canadian policies affecting refugees recommends that anthropologists, social and mental health workers, and doctors should be consulted to a greater extent than they have been in the past (Pask and Jayne, 1984).

Within the literature on preventive mental health measures, two contrasting ideological perspectives may be discerned, the "political" and the "cultural" (Jones and Korchin, 1982). The majority of recently published works advocate sensitivity to the cultural values and specific needs of the populations served (Lago, 1981; Marett, 1981). They would modify and expand existing programs and policies to assure the emotional well-being of migrants.

A few authors argue that migrants would scarcely have mental health problems were it not for the political, economic, and social circumstances in which they find themselves (Anderson and Lynam, 1986; Bodnar and Reimar, 1979; Trouvé et al., 1983). They advocate changing certain institutions of the host country, not only as a preventive mental health measure, but also as a remedial therapeutic technique (see Jones and Korchin, 1982).

This apparent contrast in perspectives may be more a matter of degree than of substance. Both schools of thought would safeguard naturally occurring preventive mechanisms -- the family, peer groups, religious communities -- and would ensure the development of social and economic opportunities for migrants within countries of resettlement.

B. TRADITIONAL HEALING IN THE IMMIGRANT CONTEXT

Despite a growing body of literature on traditional healing practices in various countries of emigration, very little has been published concerning the use of traditional practices by migrants after resettlement (K.M. Lin et al., 1982; Rack, 1982). In the Canadian context, a few studies allude to the fact that immigrants and refugees may use traditional healers, rituals, and remedies in conjunction with components of Western medical care (Beiser, 1984; Chandrasena, 1984; Sabatier and Durivage, 1986). One study is underway which will detail the use of Southeast Asian medical practices by refugees in Saskatchewan (Ervin, 1986).

Perhaps because of this lack of information, there is a lack of agreement on the significance of traditional healing to migrants experiencing psychological distress. For example, one study of Hispanic migrants in the United States found that 24 per cent of parents whose children were psychiatric patients had consulted seers for their children's problems during the previous year (Bird and Canino, 1981). Another study of the same cultural group suggests that Western researchers may place greater value on

traditional forms of interventions than do community members themselves (Gaviria and Stern, 1980).

Numerous publications attest to the value placed on traditional healing practices by many host country mental health workers. Healers from cultural communities are called upon to act as consultants, trainers, and mutual referral sources by mainstream practitioners (Bowlan and Bruno, 1985; Delgado, 1979). Traditional approaches to treatment have formed the basis of several successful outpatient and inpatient programs (Devisch and Gailly, 1985; Fox, 1984; Lu et al., 1984; Sandoval, 1979). Outreach and preventive programs in community settings have been greatly facilitated by the involvement of "culture brokers" or mediators from the cultures of the population served (Allodi and Fantini, 1985; Barwick, 1986; Lefley and Bestman, 1982).

Logically, the contrasts between the premises of Western mental health practice and those of traditional healing systems would predict antagonism between the two (Lefley, 1984). Certainly, reservation, if not outright rejection, does characterize the "scientific" attitude toward many "unscientific" beliefs and techniques (Rack, 1982). However, serious efforts have been made to understand traditional healing processes in light of recent biomedical knowledge (see for example Prince, 1984); and ultimately, as Lefley (1984) points out, the recognition of traditional healing rests on its patent benefits to the believer patient.

C. UTILIZATION OF MAINSTREAM MENTAL HEALTH SERVICES

Recent literature on the use of mainstream mental health services by migrants speaks to three areas of concern: how to ensure that migrants who need the services access them; how to assess or diagnose clients/patients cross-culturally; and how to adapt treatment approaches and therapies for persons from different cultural backgrounds.
Several publications note that community mental health programs, with their emphasis on interaction with local populations, are structurally and philosophically predisposed to addressing these issues (Allodi and Fantini, 1985; Jones and Korchin, 1982; Lefley, 1984). However, individual mental health practitioners and hospital facilities have also responded to the challenges posed by multicultural clientele.

The ideology of culturally sensitive services has already been established as an ethical imperative (Draguns, 1981; Sartorius, Pedersen and Marsella, 1984). Interest now lies in identifying and implementing specific means to that end.

1. Patterns of Referral and Attendance

The prevailing theme regarding migrants and mental health services is that of underutilization. While some studies show higher rates of hospitalization for migrants than for native-born persons (see pp. 4-5), the rates at which migrants access private mental health practitioners and community mental health services are generally low in comparison to the rates of their native-born counterparts (Allodi and Fantini, 1985; Cheung and Dobkin de Rios, 1982). It is possible that certain migrant groups "underutilize" mental health services due to high levels of emotional well-being. However, publications based on first-hand knowledge of migrants and their cultures suggest other explanations.

In the first instance, it is generally recognized that cultural conceptions of mental disorder play a major role in determining the extent to which migrants access mental health services. "Minor" disorders such as phobias and depression, and adjustments called for by bereavement or divorce, thought of by many Canadians as legitimate reasons to consult a mental health professional, may be considered a normal part of life by persons from traditional cultures (S.D. Nguyen, 1984; see also Cohon, 1977; Great Britain, Community Relations Commission, 1976). Major psychiatric disorders such as schizophrenia or organic brain disorder are conceived of in many societies as supernatural punishments for wrong-doing, and as such entail enormous shame and stigma (Kinzie, 1985; Lefley, 1984). Afflicted individuals avoid making their condition known and may be concealed by their families for extended periods of time (T.Y. Lin et al., 1978; see also Lobo, 1978; Tung, 1980).

Several authors suggest that somatic or physical disorders, to which no shame is attached, may represent a culturally acceptable means of expressing emotional problems (Mirdal, 1985; S.D. Nguyen, 1983). In a community survey of North African immigrants in Montreal, Lasry and Sigal (1980) found that self-reported physical health symptoms were the best predictors of the scores obtained from the mental health questionnaire. A similar study of Southeast Asian refugees in Vancouver revealed that individuals who had recently consulted doctors for trivial complaints were experiencing levels of emotional distress at least as high as persons who had seen doctors for serious conditions (Beiser, 1984). The implication that migrants may seek medical attention for physical problems relating to psychological states is supported by E.H. Lin, Carter and Kleinman (1985), who found that somatization accounted for 35 per cent of all illness visits made by Asian migrants in primary care (see also Vega et al., 1986).

While the literature focuses on concealment and somatization as factors affecting the use of mental health facilities, there are also indications that migrants with mental health problems may turn to volunteer agencies and self-help groups for advice and support (Cohen and Grossnickle, 1983; Lynam, 1985). A survey of 1,100 organizations serving refugees found that community mental health centres had seen only four per cent of the clients deemed to be in need of mental health services (Miller, Chambers and Coleman, 1981). However, it is difficult to determine where the preventive function of such groups ends and the remedial function begins. For example, Palinkas (1982) details how a minister of a Chinese congregation uses traditional forms of rhetoric to reduce the stress of migration, but he also notes how the minister's approach parallels that of Western therapists in dealing with psychological problems.

More research is needed to determine why migrants who do seek help for mental health problems do not seek it more often from mainstream mental health services. The existing literature suggests, but rarely documents, such factors as fear of deportation, anticipation of cultural and linguistic barriers, and simple lack of information (Aguirre and Bigelow, 1983; B.L. Kim, 1978; Selyan, 1978).

Among migrants who do access mainstream services for mental health problems, cultural factors appear to play a major role in determining attendance patterns. S. Sue (1977) found that about half of the Asian and Hispanic-American clients seen by Seattle area mental health centres over a three-year period failed to return after one session (see also Andrulis, 1977; Koranyi, Kerenyi and Sarwer-Foner, 1963). Miranda (1976) reports that among Mexican-Americans, the likelihood of continuing and succeeding in therapy is directly related to the degree of acculturation. Allodi and Fantini (1985) document how the utilization of mental health services by Italian Canadians rose when those services were made more culturally appropriate (see also Barwick, 1986; Kinzie, 1985).

2. Issues in Assessment

The assessment of individual migrant clients entails problems similar to those besetting the measurement of mental health status in migrant groups (see pp. 4-5). Language, the primary means by which a patient normally communicates symptoms and a clinician interprets them, is the most obvious problem (Rack, 1980). Inability to convey and comprehend the subtle sensations of mental disorder may lead to misdiagnosis and possibly, as at least one study suggests, to patient suicide (Myers and Neal, 1978). Even

well-translated communications may confound assessment in that the languages of the patient and the clinician may differentially favour particular affective expressions (Leff, 1977; Marsella and White, 1984), and may include culturally unique "emic" concepts of syndromes (Migliore, 1983; Pedersen et al., 1981; Westermeyer, 1985).

Language aside, cultural differences in the presentation of symptoms also complicate diagnosis of the migrant patient (Krener and Sabin, 1985; S. Sue and Morishima, 1982; Williams and Westermeyer, 1983). For example, the same ethnic groups who have been found to use primary care for somatic complaints also tend to somatize as psychiatric patients (Abad and Boyce, 1979; Lasry, 1977; S.D. Nguyen, 1984). On the other hand, patients may present with dramatically bizarre behaviour when suffering relatively minor disorders (Wilson, Ries, and Bokan, 1980). As Eisenbruch (1984) indicates, cultural differences in the expression of as common a human experience as bereavement can lead to under-diagnosis or to over-diagnosis.

The use of interpreters, an obvious answer to the problems of cross-cultural assessment, is not without its own problems (Burch and Powell, 1980; Wilson, Ries and Bokan, 1980). One study found that interpreters from the same countries as non-English-speaking patients tended to assume authoritarian roles with the patients and were responsible for distortion and misevaluation of information (Marcos, 1979). Another study found that, while patients who were interviewed through interpreters felt more satisfied than patients who were not, the psychiatrists conducting the interviews felt significantly less satisfied when using interpreters (Kline et al., 1980).

The successful use of interpreters appears to depend not only on their training and abilities, but also on the ability of practitioners to work with them. For example, with well-trained, empathetic interpreters, Kinzie (1981) was able to implement a second solution to problems of intercultural diagnosis: thorough history-taking, not unlike the open-ended interviews recommended by Eyton and Neuwirth (1984) for research on the mental health of migrant groups. On the other hand, without interpreters, Burch and Powell (1980) found they could rely on a Vietnamese adolescent's art work to assess her mental status and progress.

The other side of the interpreter coin is the culturally informed and sensitive clinician, a third possible solution. Awareness of a patient's culture enables practitioners to assess behaviour and process information within a framework that is relevant to that patient

(Devereaux, 1978; Tousignant, in press). Lack of awareness of the cultural context of presenting symptoms can easily lead to misdiagnosis (Levine and Padilla, 1980; Weidman, 1979).

Occasionally, over-sensitivity to cultural differences, and certainly cultural stereotyping, have been implicated as factors in inaccurate assessments (Marsella and Pedersen, 1981; Wampold, Casas and Atkinson, 1981; Zola, 1973). As D.W. Sue (1981) points out, intracultural differences can be as great as or greater than intercultural differences: practitioners must take care to individualize the assessment of a migrant client as they would that of a native-born person. In general, however, familiarity with the culture of a patient significantly aids practitioners in their task of diagnosis (see Westermeyer and Zimmerman, 1981).

Psychologists and psychiatrists who are themselves migrants may well combine the advantages of well-trained interpreters and culturally informed practitioners when assessing clients from their own cultures. When treating compatriots, however, it appears that similar cultural background does not necessarily predict successful therapeutic outcome (Casas, 1985; Lappin, 1983). Indeed, one study of psychiatric services for Haitian immigrants in Montreal concludes that culturally trained Canadian-born professionals can contribute to the resolution of migrants' problems better than professionals from the same cultural community (Sterlin, in press, see also Lopez, 1977).

There is also evidence that some members of migrant communities may prefer to receive treatment from persons outside those communities (Atkinson, 1983; Draguns, 1981).

3. Expectations of Therapy

The past decade has seen an enormous growth in the literature on cross-cultural counselling and psychotherapy in the immigrant context. It focuses on three aspects of treatment: the counselling relationship, the setting of therapeutic goals and programs, and the nature of the treatment process itself. In each case, the congruency or contrast of expectations between the practitioner and the patient emerges as an important variable in therapeutic outcome.

a) The counselling relationship. In cross-cultural studies, as in others, one adjective commonly used to describe the ideal therapist is "supportive" (Boehnlein et al., 1985; Hiegel, 1983; Kinzie, 1981). There are distinct variations, however, in the ways support may be demonstrated so as to be perceived as such by

migrants from different cultural backgrounds. For refugees from Southeast Asia, for example, several researchers advocate that therapists assume an authoritarian role, akin to that of a medical doctor, teacher or elder in the countries of emigration (Cohon, 1977; Okura, 1981; Santopietro and Lynch, 1980). Latin Americans, Eastern Europeans, and Indo-Pakistanis may also expect a "medical approach" to counselling, but for them an informal, familiar relationship with the therapist appears optimal (Brodsky, 1982; Canino and Canino, 1982; Wood, 1984).

Whether the relationship called for is hierarchical and formal, or egalitarian and informal, migrant patients from a range of cultural backgrounds have been found to respond to a more directive approach than Western counsellors usually employ (Ananth, 1984; Cohon, 1977; Lefley and Bestman, 1982). Okura (1981) suggests that even group therapy and support activities -- often assumed to be contra-indicated due to the shame associated with mental illness -- may be effective with migrants when conducted by a strong and directive leader. The current Western emphasis on client self-determination and decision making may conflict with a traditional migrant's expectations of direct advice (Wood, 1984).

b) Goal setting and program selection. The formulation of a culturally appropriate treatment plan entails an understanding of the meaning and perception of the disorder and its symptoms to the patient (Evans et al., 1986; Kinzie, 1981, Kleinman, Eisenberg and Good, 1978). Several case studies illustrate how etiologies in particular may be differentially interpreted by practitioners and patients from contrasting cultural backgrounds (Krieger and Zussman, 1981; Tobin and Friedman, 1983; Wilson, Ries and Bokan, 1980). Realistic goal setting and effective program selection also depend on an awareness of the patient's basic cultural values and existing cultural defenses (Ananth, 1984; Cohon, 1977; S. Sue, 1977). As Sue notes, the therapeutic process must be carefully matched to culturally acceptable therapeutic goals.

Generally speaking, the Western therapeutic goals of client independence and self-realization are singled out in the literature as particularly inappropriate for many migrant clients (Di Nicola, 1985a; Lefley, 1984; Marsella and Pedersen, 1981). As Ananth (1984) notes, the central role played by the traditional family unit in the formation of an individual's identity suggests that harmony with the family, "interdependence not

independence," should be the goal of treatment (see also Marsella and Pedersen, 1981). Moreover, persons raised within traditional families and cultures may be quite unaccustomed even to articulating, much less acting on, their personal feelings: encouragement to do so may result in a dysphoric milieu (Ananth, 1984; Okura, 1981).

Family therapy appears a logical mode of treatment for such migrant patients and is, in fact, strongly recommended by many authors (Di Nicola, 1985a; 1985b; McGoldrick, Pearce and Giordano, 1982; Falicov, 1983). As Waxler (1977) points out, in traditional cultures mental disorder is often perceived as a problem of and for the family, not the afflicted individual. However, verbal therapies which focus on the individual have been developed and successfully used with various sub-populations of migrants, including adolescents (Szapocznik, Kurtines and Fernandez, 1980), women (Marshal, 1979), and victims of torture (Allodi, in press; Kinzie et al., 1984). Moreover, elements of behaviour therapy, particularly the principles of shaping and positive reinforcement, have also proven effective with individual migrant patients (Stumphauzer and Davis, 1983).

c) Contents of therapy. As Draguns (1981) notes, the common theme which emerges from the literature is that of activity, rather than reflection, as a key ingredient in therapies for migrant patients. Various treatment modalities, including individual psychotherapy, may be effective with migrant patients to the extent that they include concrete measures perceived by the patients to be practical and relevant (Fox, 1984). For example, a doing-activity orientation has proven effective with Hispanic migrants in family therapy (Szapocznik, Scopetta and King, 1978), and resident Khmer patients in Thai refugee camps are thought to benefit from their work of growing medicinal plants and preparing remedies (Hiegel, 1983).

The "talk" that does take place between patient and therapist is circumscribed by several factors. Certain topics, such as sex or aggressive thoughts, may be culturally taboo (Ananth, 1984). Other topics, particularly for victims of torture or other recent traumas, are often avoided by patients unaccustomed to discussing even common personal feelings (Kinzie et al., 1984; Pivnicki, 1980). In such cases, an indirect approach to the subject -- discussion of real or fictitious "others in a similar position" -- may produce the desired effect (Okura, 1981).

Alternatively, some authors recommend an "emic" or "insider" approach on the part of practitioners (Devereaux, 1978; Greenbaum and Holmes, 1983). However, this approach has been challenged by others on both ethical and practical grounds (Di Nicola, 1985b; Lefley, (1984).

It appears that for migrant patients, the contents of treatment, like the setting of therapeutic goals and the nature of the counselling relationship, require cultural sensitivity and adjustment on the part of the therapist. A few studies, however, suggest that cultural adjustment can be a two-way street. Lambert and Lambert (1984) assigned 30 immigrant patients at a community mental health centre in Hawaii either to role-induction (therapy preparation) intervention or to placebo intervention. The role-prepared patients became less dependent on their therapist for support and direction, were more satisfied with the therapy they received, and dropped out of treatment at significantly lower rates. Similar results were obtained by Acosta et al. (1983), when working with Hispanic American patients.

D. ANSWERS TO OBSTACLES

When the literature on mental health services for migrants is viewed as a whole, important gaps in knowledge and understanding become apparent. Most noticeably, specific primary preventive services are described, but their implications for emotional well-being have yet to be documented. Similarly, although the value of traditional healing systems to mainstream practitioners is examined, their use by migrants remains largely unexplored.

With regard to mainstream remedial services, the gap in knowledge is of a different order. Much work has already been done on identifying generic skills which facilitate service utilization by persons of any cultural background (Brown 1982). Specific do's and don'ts have been identified regarding service delivery to at least the major cultural groups (see for example Pedersen et al., 1981). However, very few publications address the means whereby such skills and knowledge can be effectively taught and learned. This is a serious omission, for at each juncture in the mental health system, from outreach and intake to discharge and follow-up, the special problems presented by a multicultural clientele can be met, first and foremost, by education and training.

To the extent that immigrants and refugees turn to their families and cultural support groups when in emotional distress, mental health education programs should be adapted for migrant

communities (Barwick, 1986; B.L. Kim, 1976). In addition, general practitioners, school nurses and social workers should be trained to identify mental health needs in persons from other cultures, and to refer such persons in culturally sensitive ways (Ammar, 1982; Cohon, 1983; Lynam, 1985). Since a good interpreter greatly facilitates assessment and treatment, and a poor one jeopardizes the therapeutic process, appropriate persons from the communities of the clients must be trained as mental health paraprofessionals, if not professionals (Coleman, Miller and Chambers, 1979; Shackman, 1982). Finally, practitioners themselves should be sensitized at the under-graduate and post-graduate levels not only to cross-cultural differences in assessment and treatment but also to their own cultural-professional biases (Salvendy, 1983; Samuda and Wolfgang, 1985).

Unfortunately, although the literature is unanimous in recommending cross-cultural training for mental health practitioners, and mental health training for bi-cultural interpreters, detailed accounts of the substance and results of such training are sorely lacking. As D.W. Sue (1981) puts it, there is much talk and little action: time and energy are spent on consciousness raising, but not on the development of skills-oriented curricula which would enable professionals and paraprofessionals to act on that consciousness.

Moreover, the work that is done on cross-cultural training often remains unpublished, causing unnecessary duplication and re-invention (D.W. Sue, 1981). There is a need to identify existing practical resource materials, and to make them known to mental health agencies (see for example Ivey and Authier, 1978). There is also a need to evaluate the impact of such resource materials on the participants in academic courses and in-service programs which include them (see for example Van Dromme, 1977). Finally, the format and contents of successful training programs should be made known through publications, conferences, and consultants (see for example Fernandez-White, 1985).

The obstacles to mental health service utilization posed by cultural differences must be overcome in the first instance by an awareness and understanding of those differences, both on the part of migrant patients and on the part of mainstream practitioners. For practitioners, however, cultural awareness must also be translated and presented in practical, skill-oriented terms if it is to answer the challenge of mental health services for migrants.

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